Filed for intro on 02/17/2005
HOUSE BILL 2181
By Odom

SENATE BILL 2230
By Norris

AN ACT to amend Tennessee Code Annotated, Title 56, relative to health insurance.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. **Section I. Purpose**

This Act protects the citizens of this state who participate in the individual health insurance market by providing a mechanism to equitably distribute the excessive risk sometimes associated with this market and to enable insurers to better protect against the costs of covering high risk individuals. This Act establishes a high risk pool that will provide access to health insurance to all residents of the state who are denied health insurance for medical or health reasons. It is the intent of the legislature that the high risk pool shall utilize measures to promote quality and cost-effective health care services, including, but not limited to, comprehensive disease management and network-based coverage, and that measures shall be taken to avoid inappropriate shifting of costs and risk to the high risk pool.

Section II. Definitions

A. "Board" means the board of directors of the plan.

B. "Church plan" has the meaning given such term under section 3(33) of the Employee Retirement Income Security Act of 1974.

C. "Commissioner" means the Commissioner of the Department of Commerce and

Insurance.

D. 1. "Creditable coverage" means, with respect to an individual, coverage of the individual provided under any of the following:

a. a group health plan;

b. health insurance coverage;

c. Part A or Part B of Title XVIII of the Social Security Act;

d. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;

e. Chapter 55 of Title 10, United States Code;

f. a medical care program of the Indian Health Service or of a tribal organization;

g. a state health benefits risk pool;

h. a health plan offered under Chapter 89 of Title 5, United States Code;

i. a public health plan as defined in federal regulations; or

j. a health benefit plan under Section 5(e) of the Peace Corps Act, 22 U.S.C. 2504(e).

2. A period of creditable coverage shall not be counted, with respect to the enrollment of an individual who seeks coverage under this Act, if, after such period and before the enrollment date, the individual experiences a significant break in coverage.

E. "Department" means the Department of Commerce and Insurance.

F. "Federally defined eligible individual" means an individual:

1. for whom, as of the date on which the individual seeks coverage under this Act,

the aggregate of the periods of creditable coverage, as defined in subsection II.D., is eighteen (18) or more months;

2. whose most recent prior creditable coverage was under a group health plan, governmental plan, church plan, or health insurance coverage offered in connection with such a plan;

3. who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social Security Act (Medicare), or a state plan under Title XIX of the Act (Medicaid) or any successor program, and who does not have other health insurance coverage;

4. with respect to whom the most recent coverage within the period of aggregate creditable coverage was not terminated based on a factor relating to nonpayment of premiums or fraud;

5. who, if offered the option of continuation coverage under a COBRA continuation provision or under a similar state program, elected this coverage; and

6. who has exhausted continuation coverage under this provision or program, if the individual elected the continuation coverage described in paragraph II.F.5.

G. "Governmental plan" means any governmental plan as defined under section 3(32) of the Employee Retirement Income Security Act of 1974 and any federal governmental plan.

H. "Group health plan" means an employee welfare benefit plan as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care, as defined in subsection II.L., and including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement or otherwise.

I. 1. "Health insurance coverage" means any hospital and medical expense incurred policy, nonprofit health care service plan contract, health maintenance organization subscriber contract, or any other health care plan or arrangement that pays for or furnishes medical or health care services, whether by insurance or otherwise.

2. "Health insurance coverage" shall not include one or more, or any combination of, the following:

a. coverage only for accident, or disability income insurance, or any combination thereof;

b. coverage issued as a supplement to liability insurance;

c. liability insurance, including general liability insurance and automobile liability insurance;

d. workers compensation or similar insurance;

e. automobile medical payment insurance;

f. credit-only insurance;

g. coverage for on-site medical clinics; and

h. other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits.

3. "Health insurance coverage" shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the coverage:

a. limited scope dental or vision benefits;

b. benefits for long-term care, nursing home care, home health care,

community-based care, or any combination thereof; or

c. other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.

4. "Health insurance coverage" shall not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

a. coverage only for a specified disease or illness; or

b. hospital indemnity or other fixed indemnity insurance.

5. "Health insurance coverage" shall not include the following if offered as a separate policy, certificate or contract of insurance:

a. Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;

b. coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); or

c. similar supplemental coverage provided to coverage under a group health plan.

J. "Health maintenance organization" means an organization licensed under Chapter 32 of Title 56.

K. "Insurer" means any entity that provides health insurance coverage in this state. For the purposes of this Act, insurer includes an insurance company, hospital and medical services corporation, a health maintenance organization, and any other entity providing a plan of health insurance coverage or health benefits subject to state insurance regulation.

L. "Medical care" means amounts paid for:

1. the diagnosis, care, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

2. transportation primarily for and essential to medical care referred to in paragraph II.L.1.; and

3. insurance covering medical care referred to in paragraphs II.L.1. and 2.

M. "Medicare" means coverage under both Parts A and B of Title XVIII of the Social Security Act, 42 USC 1395 et seq., as amended.

N. "Plan" means the Tennessee Health Insurance Plan as created in Section III. of this Act.

O. "Plan of operation" means the articles, bylaws, and operating rules and procedures adopted by the board pursuant to Section III of this Act.

P. "Resident" means an individual who has been legally domiciled in this state for a period of at least twelve (12) months, except that for a federally-defined eligible individual, there shall not be any twelve (12) month requirement.

Q. "Significant break in coverage" means a period of sixty-three (63) consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage.

R. “Trade adjustment assistance eligible individual” means a resident who is eligible for the tax credit for health insurance coverage premiums under section 35 of the Internal Revenue Code of 1986.

Section III. Operation of the plan

A. There is hereby created the Tennessee Health Insurance Plan.

B. The plan shall operate subject to the supervision and control of the board. The board shall consist of the commissioner or his or her designated representative, who shall serve as an ex officio member of the board and shall be its chairperson, and eight (8) members appointed by the governor. At least two (2) board members shall be individuals, or the parent, spouse or child of individuals, reasonably expected to qualify for coverage by the plan. At least two (2) board members shall be representatives of insurers or their agents. A majority of the board shall be composed of individuals who are not representatives of insurers or health care providers.

C. The initial board members shall be appointed as follows:

1. one-third of the members to serve a term of two (2) years;
2. one-third of the members to serve a term of four (4) years; and

3. one-third of the members to serve a term of six (6) years.

Subsequent board members shall serve for a term of three (3) years. A board member's term shall continue until his or her successor is appointed.

D. Vacancies in the board shall be filled by the governor. Board members may be removed by the governor for cause.

E. Board members shall not be compensated in their capacity as board members but shall be reimbursed for reasonable expenses incurred in the necessary performance of their duties.

F. The board shall submit to the commissioner a plan of operation for the plan and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the plan. The plan of operation shall become effective upon approval in writing by the commissioner consistent with the date on which the coverage under this Act must be made available. If the board fails to submit a suitable plan of operation within one hundred eighty (180) days after the appointment of the board of directors, or at any time thereafter fails to submit suitable amendments to the plan of operation, the commissioner shall adopt and promulgate such rules as are necessary or advisable to effectuate the provisions of this Section III. Such rules shall continue in force until modified by the commissioner or superseded by a plan of operation submitted by the board and approved by the commissioner.

G. 1. The plan of operation shall:

a. establish procedures for operation of the plan;

b. establish procedures for selecting an administrator in accordance with

Section VII.;

c. establish procedures to create a fund, under management of the board, for administrative expenses;

d. establish procedures for the handling, accounting and auditing of assets, monies and claims of the plan and the plan administrator;

e. develop and implement a program to publicize the existence of the plan, the eligibility requirements, and procedures for enrollment, and to maintain public awareness of the plan;

f. establish procedures under which applicants and participants may have grievances reviewed by a grievance committee appointed by the board;

g. develop and implement programs, such as a comprehensive disease management program, to deliver high-quality and cost-effective health care services to plan participants;

h. provide for the delivery of cost-effective health care services, including, to the extent feasible, entering into contracts with preferred provider organizations, health maintenance organizations, and other limited network provider arrangements; and

i. provide for other matters as may be necessary and proper for the execution of the board's powers, duties, and obligations under this Act.

2. The grievance procedures established under subparagraph III.G.1.f. shall include, at a minimum, the following requirements:

a. the grievance committee shall make a report to the board after completion of a review by the grievance committee; and

b. the board shall retain all written complaints regarding the plan for at least three (3) years.

H. The plan shall have the general powers and authority granted under the laws of this state to health insurers and in addition thereto, the specific authority to:

1. enter into contracts as are necessary or proper to carry out the provisions and purposes of this Act, including the authority, with the approval of the commissioner, to enter into contracts with similar plans of other states for the joint performance of common administrative functions, or with persons or other organizations for the performance of administrative functions;

2. sue or be sued, including taking any legal actions necessary or proper to recover or collect assessments due the plan;

3. take such legal action as necessary to

a. avoid the payment of improper claims against the plan or the coverage provided by or through the plan,

b. recover any amounts erroneously or improperly paid by the plan,

c. recover any amounts paid by the plan as a result of mistake of fact or law, or

d. recover other amounts due the plan;

4. establish, and modify from time to time as appropriate, rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, claim reserve formulas, and any other actuarial function appropriate to the operation of the plan, provided that rates and rate schedules may be adjusted for appropriate factors such as age, sex, and geographic variation in claim cost and shall take into consideration appropriate factors in accordance with established actuarial and underwriting practices;

5. issue policies of insurance in accordance with the requirements of this Act;

6. appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the plan, policy, and other contract design, and

any other function within the authority of the pool;

7. borrow money to effect the purposes of the plan, provided that any notes or other evidence of indebtedness of the plan not in default shall be legal investments for insurers and may be carried as admitted assets;

8. employ and fix the compensation of employees, who may be paid on a warrant issued by the state treasurer pursuant to a payroll voucher certified by the board and drawn by the comptroller against appropriations or trust funds held by the state treasurer;

9. prepare and distribute certificate of eligibility forms and enrollment instruction forms to insurance producers and to the general public;

10. provide for reinsurance of risks incurred by the plan;

11. provide for and employ measures and requirements including, but not limited to, comprehensive disease management, preadmission screening, second surgical opinion, concurrent utilization review, and individual case management, for the purpose of providing high-quality and cost-effective health care services to plan participants;

12. design, utilize, contract, or otherwise arrange for the delivery of cost-effective health care services, including establishing or contracting with preferred provider organizations, health maintenance organizations, and other limited network provider arrangements;

13. establish the amount or level of reimbursement to health care providers who provide services to plan participants; and

14. adopt bylaws, policies and procedures as may be necessary or convenient for the implementation of this Act and the operation of the plan.

I. The board shall make an annual report to the governor which shall also be filed with the legislature. The report shall summarize the activities of the plan in the preceding calendar year, including the net written and earned premiums, plan enrollment, the expense of administration,

and the paid and incurred losses.

J. Neither the board nor its employees shall be liable for any obligations of the plan. No member or employee of the board shall be liable, and no cause of action of any nature may arise against them, for any act or omission related to the performance of their powers and duties under this Act, unless such act or omission constitutes willful or wanton misconduct. The board may provide in its bylaws or rules for indemnification of, and legal representation for, its members and employees.

Section IV. Establishment of rules

The commissioner may, by rule, establish additional powers and duties of the board and may adopt such rules as are necessary and proper to implement this Act.

Section V. Eligibility

A. 1. An individual person, who is and continues to be a resident shall be eligible for plan coverage if evidence is provided:

a. of two notices of rejection or refusal to issue substantially similar insurance for health reasons by one insurer; or

b. of a refusal by an insurer to issue insurance except at a rate exceeding the plan rate.

2. A federally defined eligible individual who has not experienced a significant break in coverage and who is and continues to be a resident shall be eligible for plan coverage.

3. A rejection or refusal by an insurer offering only stop loss, excess of loss, or reinsurance coverage with respect to an applicant under paragraph V.A.1. shall not be sufficient evidence under this subsection V.A.

B. The board shall promulgate a list of medical or health conditions for which a person shall be eligible for plan coverage without applying for health insurance coverage pursuant to paragraph V.A.1. Persons who can demonstrate the existence or history of any medical or health conditions on the list promulgated by the board shall not be required to provide the evidence specified in paragraph V.A.1. The list shall be effective on the first day of the operation of the plan and may be amended from time to time as may be appropriate.

C. A person shall not be eligible for coverage under the plan if:

1. the person has or obtains health insurance coverage substantially similar to or more comprehensive than a plan policy, or would be eligible to have coverage if the person elected to obtain it, except that

a. a person may maintain other coverage for the period of time the person is satisfying any preexisting condition waiting period under a plan policy, and

b. a person may maintain plan coverage for the period of time the person is satisfying a preexisting condition waiting period under another health insurance policy intended to replace the plan policy;

2. the person is determined to be eligible for health care benefits under TennCare or Medicaid;

3. the person has previously terminated plan coverage, unless twelve (12) months have lapsed since such termination, except that this subparagraph V.C.3. shall not apply with respect to an applicant who is a federally defined eligible individual;

4. the person has exhausted the lifetime limits under the plan's coverage;

5. the person is an inmate or resident of a public institution, except if the person is a federally defined eligible individual; or

6. the person's premiums are paid for or reimbursed under any government sponsored program or by any government agency or health care provider, except as an otherwise qualifying full-time employee of a government agency or health care provider.

7. the person was or is eligible for coverage under the Tennessee Health Insurance Portability, Availability and Renewability Act, or the Federal Health Insurance Portability and Accountability Act of 1996.

D. Coverage shall cease:

1. on the date a person is no longer a resident of this state;

2. on the date a person requests coverage to end;

3. upon the death of the covered person;

4. on the date state law requires cancellation of the policy;

5. on the date a person ceases to be eligible for coverage under subsection V.C.; or

5. at the option of the plan, thirty (30) days after the plan makes any inquiry concerning the person's eligibility or place of residence to which the person does not reply.

E. If a person has paid premium for a period of time after the cessation of coverage under subsection V.D., the plan shall make a pro rata refund of premium to the person.

Section VI. Unfair referral to plan

A. It shall constitute an unfair trade practice for the purposes of Chapter 8, Title 56 for an

insurer, insurance producer, or third-party administrator to refer an individual employee to the plan, or arrange for an individual employee to apply to the plan, for the purpose of separating that employee from group health insurance coverage provided in connection with the employee's employment.

B. The commissioner shall review the information collected by the administrator under paragraph VII. C. 1. to determine potential unfair trade practices under subsection VI.A. and shall track violations of Chapter 8, Title 56 to determine if an insurer, insurance producer, or third-party administrator has engaged in a pattern of unfair referrals. If the commissioner finds that an insurer, insurance producer, or third-party administrator has engaged in a pattern of unfair referrals, then the commissioner shall, in addition to any penalties applicable under Chapter 8, Title 56, impose a penalty on the insurer, insurance producer, or third-party administrator, up to and including the revocation of the license or certificate of authority of the insurer, insurance producer, or third-party administrator.

Section VII. Plan administrator

A. The board shall select a plan administrator through a competitive bidding process to administer the plan. The board shall evaluate bids submitted based on criteria established by the board which shall include:

1. the plan administrator's proven ability to handle health insurance coverage for individuals;

2. the efficiency and timeliness of the plan administrator's claim processing procedures;

3. an estimate of total charges for administering the plan;

4. the plan administrator's ability to apply effective cost containment programs,

disease management programs, and other programs and procedures to administer the plan in a cost-efficient manner; and

5. the financial condition and stability of the plan administrator.

B. 1. The plan administrator shall serve for a period specified in the contract between the plan and the plan administrator subject to removal for cause and subject to any terms, conditions, and limitations of the contract between the plan and the plan administrator.

2. At least one year prior to the expiration of each period of service by a plan administrator, the board shall invite eligible entities, including the current plan administrator, to submit bids to serve as the plan administrator. Selection of the plan administrator for the succeeding period shall be made at least six (6) months prior to the end of the current period.

C. The plan administrator shall perform such functions relating to the plan as may be assigned to it, including:

1. determination of eligibility and collection of information regarding unfair referrals;

2. payment of claims;

3. establishment of a premium billing procedure for collection of premium from persons covered under the plan;

4. implementation of programs, such as a comprehensive disease management program, to deliver high-quality and cost-effective health care services;

5. delivery of cost-effective health care services, including, to the extent feasible, entering into contracts with preferred provider organizations, health maintenance organizations, and other limited network provider arrangements; and

6. other necessary functions to assure timely payment of benefits to covered

persons under the plan.

D. The plan administrator shall submit regular reports to the board regarding the operation of the plan. The frequency, content, and form of the report shall be specified in the contract between the board and the plan administrator.

E. Following the close of each calendar year, the plan administrator shall determine net written and earned premiums, the expense of administration, and the paid and incurred losses for the year and report this information to the board and the department on a form prescribed by the commissioner.

F. The plan administrator shall be paid as provided in the contract between the plan and the plan administrator.

Section VIII. Funding of the plan

A. 1. The plan shall establish premium rates for plan coverage as provided in paragraph VIII.A.2. Separate schedules of premium rates based on age, sex and geographical location may apply for individual risks. Premium rates and schedules shall be submitted to the commissioner for approval prior to use.

2. The plan, with the assistance of the commissioner, shall determine a standard risk rate by considering the premium rates charged by other insurers offering health insurance coverage to individuals. The standard risk rate shall be established using reasonable actuarial techniques, and shall reflect anticipated experience and expenses for such coverage. Initial rates for plan coverage shall not be less than less than one hundred fifty percent (150%) of

rates established as applicable for individual standard risks. Subject to the limits provided in this paragraph VIII.A.2., subsequent rates shall be established to provide fully for the expected costs of claims, including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described herein. In no event shall plan rates exceed two hundred percent (200%) percent of rates applicable to individual standard risks.

B. The deficit incurred by the plan shall be funded through amounts appropriated by the state legislature and through any monies received under the provisions of subsection VIII.C. The board shall operate the plan in a manner so that the estimated cost of providing health insurance coverage during any fiscal year will not exceed total income the plan expects to receive from policy premiums, funds appropriated by the state legislature, and monies received under the provisions of subsection VIII.C. After determining the amount of funds appropriated to it for a fiscal year, the board shall estimate the number of new policies it believes the plan has the financial capacity to insure during that year so that costs do not exceed income. The board shall take steps necessary to assure that plan enrollment does not exceed the number of residents it has estimated it has the financial capacity to insure.

C. The board shall make application for any federal grants or other federal sources under which the plan may be eligible to receive monies. To the extent allowable, the board shall use any monies received from a federal grant or other source to offset plan deficits.

Section IX. Benefits

A. 1. Subject to the provisions of subsection IX.B., the plans to be issued by the pool,

including schedules of benefits, exclusions, and other limitations, shall be established by the board subject to the approval of the commissioner. In establishing the plans, the board shall take into consideration the levels of health insurance coverage provided in the state and medical economic factors as may be deemed appropriate and shall promulgate benefit levels, deductibles, coinsurance factors, exclusions, and limitations determined to be generally reflective of and commensurate with comprehensive, major medical health insurance coverage provided in the state.

2. a. The board shall, utilizing standard morbidity assumptions, annually place a value on all plans presently being written or issued in the individual market. Theboard shall average these values, weighed according to each plan's written premium volume, or some other suitable proxy, and, utilizing the same standard morbidity assumptions, shall develop two (2) coverage options, Option A and Option B.

b. The value of Option A developed by the board shall be ten percent (10%) higher than the average value computed under subparagraph IX.A.2.a. and the value of Option B shall be ten percent (10%) lower than the average value computed under subparagraph IX.A.2.a. The board shall also provide either a managed care or network-based version of Option A and Option B.

B. No preexisting condition exclusion in any of the plans shall be applied to a federally defined eligible individual or to a trade adjustment assistance eligible individual with three months or more of creditable coverage at the time the trade adjustment assistance eligible individual makes application for coverage.

C. 1. The plan shall be payor of last resort of benefits whenever any other benefit or

source of third-party payment is available. Benefits otherwise payable under plan coverage shall be reduced by all amounts paid or payable through any other health insurance coverage and by all hospital and medical expense benefits paid or payable under any workers compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program.

2. The plan shall have a cause of action against an eligible person for the recovery of the amount of benefits paid that are not for covered expenses. Benefits due from the plan may be reduced or refused as a set-off against any amount recoverable under this paragraph X.C.2.

Section X. Taxation

The plan established pursuant to this Act shall be exempt from any and all taxes.

Section XI. Providers

All health care providers, including physicians, hospitals, and other institutions, firms, organizations, entities and natural persons who provide health care services to persons under the provisions of this Act shall be immune from suit arising from such services, except for willful, wanton or gross negligence.

Section XII. Effective date

This Act shall become effective on July 1, 2005.